Public Hearing on CON Standards
Lansing, Michigan
January 31, 2006

Need for Adjustments to MRI Standards

Good morning. My name is Walter Wheeler and I am here today to comment on the MRI standards on behalf of Bell Memorial Hospital-- a 25 bed "Critical Access Hospital" located in Ishpeming.

By way of background, the Critical Access Hospital Program was created by the federal government in 1997 as a safety net to assure access to health care services in rural areas. It helps smaller rural hospitals to stay financially healthy and requires them to maintain quality, accessible and affordable services in their communities. It is good for communities, good for economic development and good for health.

Critical access hospitals are small-- 25 beds or less. They are situated in a rural or micropolitan area, and are located more than 35 miles from any other hospital (or more than 15 miles from another hospital in areas with a lot of snow and only secondary roads).

Michigan has 34 critical access hospitals which are each fully licensed and subject to CON.

Among other things, many critical access hospitals provide orthopedic services-- a medical service people need and expect to have available close to where they live.

By today's standards, quality orthopedic care involves MRI services which are available when the patient needs them-

especially in emergencies. A continuously available fixed unit allows a hospital to provide this level of care more effectively than if it is limited to a mobile unit available only a few days a month.

In the case of rural hospitals such as Bell Memorial, the inability to obtain continuously available MRI services undermines the continuity of community care and weakens programs to enhance access-- such as the Critical Access Hospital Program.

CON standards which prohibit services in limited access areas should be carefully monitored and amended if circumstances change. This happened in 2004 when Section 3 of the MRI standards was amended to reduce the volume of cases required to convert from a mobile to a fixed unit from 6,000 cases to 4,000 cases in limited access areas.

The problem, however, is that because of their relatively small size and low patient volumes, individual critical access hospitals are still prevented from converting from a mobile to a fixed MRI unit. This means their communities have access only to intermittent services purchased as a mobile MRI host site.

When it comes to meeting the volume requirements for conversion from a mobile to a fixed MRI, rural hospitals are in a "catch-22" situation. On most days, the cases requiring an MRI are there, but the mobile MRI unit is not! A mobile unit, available only for a limited number of days in a month, is not at the hospital often enough to generate the volume needed to convert to a fixed unit.

In rural communities MRI waiting lists extend for months. In many cases citizens are required to travel to remote MRI units for service. It is particularly difficult for senior citizens to travel to distant cities for services in large, unfamiliar institutions. It is a situation that is exactly the opposite of the purpose of the Critical Access Hospital Program, which is to keep services in local areas.

The reason the standards originally favored mobile units over fixed units was to contain MRI costs. This made sense when the cost of a fixed unit was extremely high and the cost of shared mobile services was relatively low. But with today's technology the cost of a fixed MRI unit can actually be less than the cost of renting time on a mobile unit.

First, the cost of fixed units has gone way down. Second, mobile central service providers know that most host sites have no chance of converting to a fixed unit under the current standards and therefore have no competition and no incentive to reduce or contain costs.

Here is a real example of the problem:

In the case of Bell Memorial the cost of renting time on the available mobile unit is now $3,972.00 per day (a half a day costs $2186.00). Even when access is limited to 8 days per month, the monthly cost of the mobile service is about $32,000.

At today's prices, however, Bell could purchase a brand new fixed unit for about $1,000,000, and could finance it for about $19,000 per month. This is a monthly savings of at least $13,000 for more effective and continuously accessible MRI services in the community. A refurbished fixed unit would cost even less.

The bottom line is that Michigan's rural communities can have greater access to quality MRI services at less cost if the MRI standards are amended allow conversion from a mobile route in rural areas when substantial cost savings can be shown and the other non-volume criteria can be met.

We are not talking about a deluge of new conversions or changes that would materially change the standards. We are only talking

about a tweak to the standards that will permit conversion from mobile to fixed units in low access areas when the applicant can demonstrate clear cost savings. This will be within the limited existing exception.

We would like to work with the Commission staff to craft a very limited amendment to Section 3 of the Standards to increase access to fixed MRI services in rural communities when cost savings can be clearly demonstrated. This is common sense and totally consistent with the purposes of CON program to promote cost containment, quality improvement and access to needed services.

Thank you for your time.